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KANSAS HEALTH POLICY AUTHORITY

Office of the Inspector General

A PERFORMANCE AUDIT OF KHPA'S MEDICAID PROVIDER ENROLLMENT AND TERMINATIONS

Does KHPA Have Effective Controls Over Enrollment, Termination and Payments to Excluded Providers?

A Report to the Kansas Health Policy Authority Board

April 2011

11PA02

OFFICE OF THE INSPECTOR GENERAL
KANSAS HEALTH POLICY AUTHORITY

The Kansas Health Policy Authority (KHPA) Office of Inspector General (OIG) was created by the 2007 Kansas Legislature as part of a much larger health reform bill, commonly referred to as Senate Bill 11. This creation of an independent oversight body, with the responsibility to review and investigate KHPA's performance in delivering health services, was a significant step in reforming public health care in Kansas.

The KHPA OIG, whose enabling statute is K.S.A. 75-7427, is the first statutorily created Office of Inspector General in Kansas. Its mission is:

- To provide increased accountability and integrity in KHPA programs and operations;
- To help improve KHPA programs and operations; and
- To identify and deter fraud, waste, abuse and illegal acts in the State Medicaid Program, the MediKan Program and the State Children's Health Insurance Program.

To fulfill its mission, the KHPA OIG conducts:

- Investigations of fraud, waste, abuse, and illegal acts by KHPA or its agents, employees, vendors, contractors, consumers, clients, health care providers or other providers.
- Audits of the KHPA, its employees, contractors, vendors and health care providers.
- Reviews, which may also be called inspections or evaluations.

The KHPA OIG conducts its audits in accordance with applicable government auditing standards set forth by the U.S. Government Accountability Office and its reviews and investigations in accordance with the Quality Standards for Investigations, Inspections, Evaluations, and Reviews of the Association of Inspectors General.

As required by K.S.A. 75-7427, the KHPA OIG will report findings of fraud, waste, abuse or illegal acts to KHPA and also refer those findings to the Attorney General.

The current Inspector General, Nicholas M. Kramer, was appointed by the KHPA Board in September 2009. His professional certifications include Certified Inspector General, Certified Public Accountant, Certified Internal Auditor, and Certified Information Systems Auditor. Other members of the team are: Felany Opiso-Williams, Auditor; Stephen Mhere, Data Auditor and Kimberly Epps, Program Specialist.

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Executive Summary

The Federal government has enacted laws and instituted a system of procedural requirements designed to protect the integrity of the Medicaid program by excluding wrongdoers from participating in federally-funded healthcare programs. The Health and Human Services Office of Inspector General (HHS OIG) and the General Services Administration (GSA) generate and make available to the public two separate databases: the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) respectively. State healthcare agencies are required to terminate the enrollment of providers who are included on these lists and ensure that "excluded" providers are not allowed to enroll. The law, combined with state and federal oversight, enhances program integrity, reduces exposure to fraud, and protects Medicaid beneficiaries from abusive practitioners.

The KHPA OIG auditors sought to answer the following questions with regard to KHPA's administration of these requirements:

- Does KHPA, upon receiving official notification of a provider's exclusion, terminate the excluded provider from participation in Kansas Medicaid?

- Do KHPA's existing controls prevent excluded providers from enrolling in Kansas Medicaid?

- Do KHPA's existing controls prevent payment to excluded providers for any services they rendered after the termination date?

- Do KHPA's existing controls prevent payment for services rendered by excluded individuals?

We conducted a preliminary review, researching the law and interviewing KHPA staff responsible for enrollment and termination of providers. The primary focus of our work was matching provider information in the LEIE and the EPLS databases with KHPA's Medicaid Management Information System (MMIS) provider list. We then checked to see if KHPA paid claims billed for services related to any of the excluded individuals.

Here are the KHPA OIG findings related to the audit questions:

- KHPA terminates all KMAP-enrolled excluded providers upon notification of exclusion from CMS, as required by law.

- KHPA's enrollment process is effective in preventing excluded providers from enrolling in KMAP. Before authorizing a provider's enrollment, KHPA's fiscal agent staff checks the exclusion lists to ensure the applicant is not excluded. However, KHPA could strengthen this control by requiring all participating providers to furnish a social security number (SSN) on their enrollment forms. There is a line on the application form for the SSN, but KHPA accepts applications that do not include the SSN. Although the federal LEIE and EPLS databases do not make SSNs available for viewing, they do allow manual verification by name and SSN on their websites, which KHPA staff utilize to verify enrolling or participating providers who report their SSNs.

- KHPA's system of controls appears to effectively ensure that KHPA does not make payments to excluded *billing* providers for services provided after their date of exclusion. The OIG did not find any payments KHPA made to excluded Medicaid *billing* providers for the period beginning July 1, 1999 through June 30, 2010.

  KHPA also has an edit in the system designed to suspend or deny claims associated with non-billing excluded providers. However, despite having this edit, KHPA still paid claims to several business entities during the audit period that appear to have utilized the services of excluded *non-billing* physicians as performing, attending, surgical or prescribing providers. Although they did not submit bills directly, the institutions where they worked submitted numerous claims that were paid with Medicaid funds. Most of these payments were made prior to 2005, before KHPA came into existence, although some were made as recently as 2009. In total, OIG auditors identified about $4 million in questionable claims and passed this list to KHPA management so they could conduct a detailed review and seek recoupment if warranted.

Federal law stipulates the following:

- No payment shall be made for services furnished, ordered, or prescribed by an excluded individual or business entity, and

- No payment shall be made to an entity that employs an excluded individual, even if the individual only provides administrative or management services.

The institutions that hired or used the services of the excluded physicians may not have checked or may have disregarded the federal exclusion lists. KHPA should emphasize to provider organizations the risk of employing or utilizing the services of excluded individuals.

The Patient Protection and Affordable Care Act (PPACA) requires broader and more comprehensive provider screening[1] before enrollment in both Medicaid and SCHIP (State Children's Health Insurance Program), and emphasizes the disclosure of information related to owners, officers, managing employees and related parties. KHPA has recognized these requirements and is working on a plan to achieve the objective of tighter control.

Auditors' Recommendations

1. KHPA program officials should ensure the KMAP enrollment applications include all federally-required information and should reject incomplete applications, such as those that do not provide the social security number of applicants, e.g. each individual in a group practice, and the taxpayer identification number of the provider organization.

2. KHPA program officials should review, modify and apply edits and other program controls to deny or suspend claims for services provided by non-billing excluded providers.

3. KHPA management should review all payments to businesses that may have utilized the services of excluded individuals and should seek recoupment if warranted.

4. KHPA program officials should improve applicable provider manuals by including specific instructions to providers to check the exclusion lists before utilizing the services of any individual or entity, and by clearly stating that reimbursement cannot be claimed for services provided by excluded individuals.

[1] http://www.federalregister.gov/articles/2010/09/23/2010-23579/medicare-medicaid-and-childrens-health-insurance-programs-additional-screening-requirements#p-70

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Audit Scope and Methodology

Healthcare providers who break the law or submit claims for excessive charges or unnecessary services may be excluded by the federal government from further participation in Medicaid and other federal healthcare programs. To ensure that excluded providers are effectively barred from participation nationwide, the Health and Human Services and the General Services Administration generate and make available to the public two databases that list excluded providers. State healthcare agencies are required to use these lists to terminate the participation of the offending providers in each state's Medicaid program.

The purpose of this audit is to determine whether KHPA employs effective controls and processes to do the following:

- Prevent excluded providers from enrolling in Kansas Medicaid.
- Identify currently participating excluded providers for termination.
- Identify related payments for recoupment.

Federal laws[2] require that no excluded person can receive any compensation from federal health care programs, contracts, and certain federal financial and nonfinancial assistance and benefits. Providers may be excluded for a variety of reasons, including conviction relating to patient abuse, health care fraud, and license revocation or suspension.[3]

To complete this audit, we reviewed applicable State and federal laws and regulations. We also interviewed KHPA and fiscal agent SURS staff, as well as, the KHPA provider and consumer relations manager to understand existing processes and controls related to excluded providers. We obtained the HHS OIG LEIE database and the GSA EPLS database in October, and conducted computer-aided data matching with the MMIS provider list. Our analysis focused on direct billing providers and the following indirect billing providers: performing, attending, surgical and prescribing providers. We also reviewed provider enrollment files of certain providers.

We did not assess the validity of MMIS data but relied on the Statement on Auditing Standards 70 (SAS-70) annual review process and the CMS certification review process. We also did not assess the validity of the LEIE and EPLS datasets. Our computer-assisted data matching may not have identified all excluded providers enrolled in Kansas Medicaid due to errors in the data, inconsistent data formats and typos. We did not conduct a detailed review of excluded providers enrolled with KHPA's managed care organizations, which conduct separate enrollment and

[2] Social Security Act (the Act) sections 1128 and 1128A, 31 U.S.C. 6101, E.O. 12549, E.O. 12689, 48 CFR 9.404, and each agency's codification of the Common Rule for Nonprocurement suspension and debarment. Also, see http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm.

[3] See page 6 for additional examples.

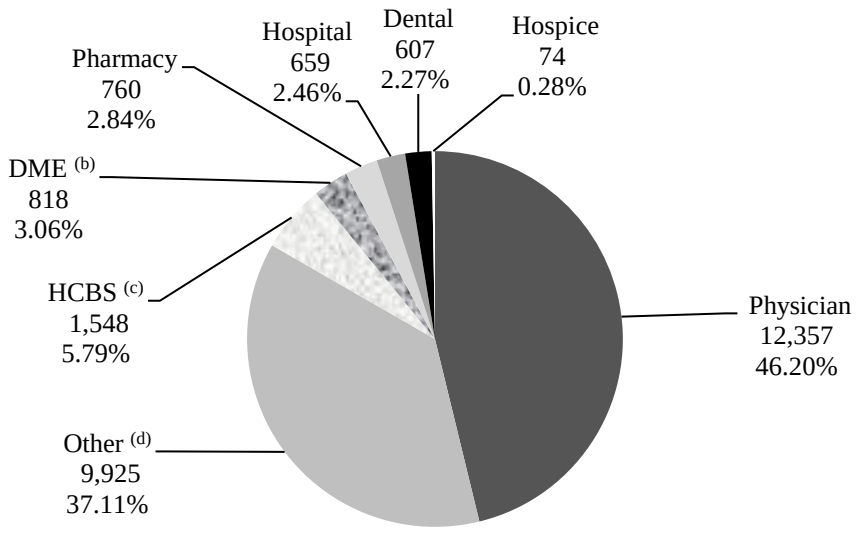
termination of their network providers. We also did not conduct analyses related to owners, officers, managing employees and related parties, since related findings have already been included in a 2010 CMS program integrity review of Kansas Medicaid. Furthermore, we have excluded personal care attendants (PCAs) from our analysis because they are not required to enroll as Medicaid providers and no PCA information is available in the MMIS. If additional analyses had been performed, other reportable matters might have come to our attention that may need corrective action. Such procedures would require more time than was intended for this audit.

Overview of KHPA's Enrollment and Termination Process

Medicaid is a health program designed to provide medical care primarily for low income individuals, people with disabilities and the elderly. The program is jointly funded by the state and federal governments and is managed by the states. The Kansas Legislature tasked the Kansas Health Policy Authority (KHPA) with administering the Medicaid program under K.S.A. 75-7405.

Each medical provider who performs services covered under Medicaid or the State Children's Health Insurance Program (SCHIP), including those within a group practice, must be individually enrolled in the Kansas Medical Assistance Program (KMAP). Therefore, as group practices enroll or as new providers join a group, each individual must enroll separately.[4] In fiscal year (FY) 2010, there were 26,748 providers enrolled in the Medicaid program. Chart OV-1 shows the types and corresponding numbers of providers for that fiscal year.

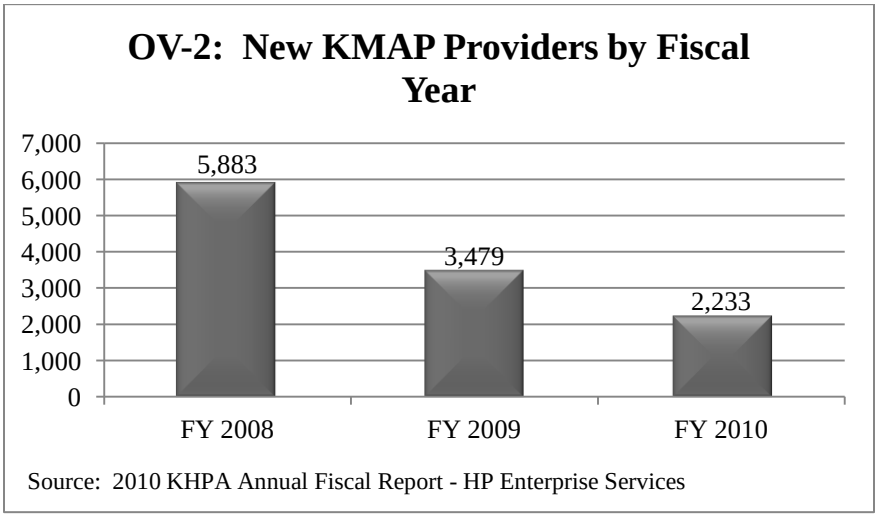
OV-1: FY 2010 KMAP Providers by Type of Service[(a)]



(a) There were 26,748 participating KMAP providers in FY 2010.
(b) Durable Medical Equipment
(c) Home and Community Based Services
(d) Other includes: Chiropractors, Nurses, Therapists, Laboratory and 30 more provider types.
Source: 2010 KHPA Annual Fiscal Report - HP Enterprise Services

[4] KMAP General Introduction Provider Manual, rev. 5/26/10, p. ii

Chart OV-2 below illustrates the number of new providers enrolled from FY 2008-2010. The high number of provider enrollments in FY 2008 was due to KHPA contracting with the Prepaid Inpatient Health Plan (PIHP) and the Prepaid Ambulatory Health Plan (PAHP) managed care organizations (MCOs). Also, KHPA contracted with Children's Mercy Family Health Partners and UniCare in FY 2008. These MCOs could have had some providers who were already part of their networks enroll with KMAP who had not been previously enrolled. The drop in provider enrollments in FY 2010 was due to KHPA no longer directly enrolling Non-Emergency Medical Transportation (NEMT) providers as of November 2009 after they contracted with an NEMT broker.



Applications for provider enrollment are processed by HP Enterprise Services staff and overseen by the KHPA contracts and program compliance manager and the provider and consumer relations manager. According to KHPA provider enrollment staff, the average number of days to process enrollments in FY 2008-2010 was:

- FY 2008 - less than one day
- FY 2009 - 3.4 days
- FY 2010 - 2.1 days.

HP Enterprise Services is required to process provider applications and updates within five business days of receipt and notify providers of acceptance or rejection within 10 business days of receipt of the application.

Provider Enrollment

Providers begin the enrollment process by completing the provider application form found on the KMAP website.[5] There are different application forms for each type of provider entity, including: Physician, Dentist, Rural Health Clinic, Hospital and Durable Medical Equipment (DME) providers. Information and documentation that a physician must provide include:

- Completed KMAP provider application, including staff membership and malpractice information and specialty listing.
- A Provider Binder.[6]
- Disclosure of Ownership and Control Interest Statement.
- KMAP Provider Agreement.
- Current License.
- W-9 (Request for Taxpayer Identification Number and Certification).
- HealthConnect Kansas Contract.

KHPA has three sets of controls designed to ensure excluded providers are not providing services to Medicaid beneficiaries. There are controls at enrollment, at exclusion (termination) and upon claims payments.

The enrollment process is designed to ensure excluded billing providers are not rendering service to Medicaid beneficiaries, among others. Applicants must disclose information such as convictions, associates and related parties upon enrollment in Kansas Medicaid.[7] In addition, KHPA verifies that the provider is not on the List of Excluded Individuals/Entities (LEIE) or Excluded Parties List System (EPLS) exclusion lists, which prohibit excluded providers from participation in Medicare or state health care programs.[8]

An ongoing system control is the verification that providers have not been added to the LEIE and EPLS exclusion lists. KHPA's fiscal agent staff queries these lists monthly to see if any providers have been excluded from providing services to Medicaid patients. By signing the Provider Binder upon enrollment, providers agree to notify the fiscal agent when there is any change to the information on their application, including but not limited to address, group affiliation, and change of ownership or tax identification number.

[5] Applications can be accessed at: https://www.kmap-state-ks.us/Public/Provider.asp.
[6] The Provider Binder certifies that under penalty of perjury, the information and statements on the application and on any accompanying documents are accurate and true.
[7] Required by Federal regulations 42 CFR 455.104 to 42 CFR 455.106
[8] Reasons for exclusion are defined in 42 USC1320a-7 and later in the Exclusion section of this overview.

Exclusions

Providers may be terminated from participation in Kansas Medicaid for reasons listed in Kansas Administrative Regulation (K.A.R.) 30-5-60. This list includes "the suspension or exclusion by the Secretary of Health and Human Services from the Title XVIII or Title XIX programs." KHPA mentions these termination reasons in its General Benefits provider manual.[9]

Since 1977, the Secretary of Health and Human Services (HHS) has had the authority to exclude certain individuals and entities from Medicaid.[10] There are two types of exclusions: mandatory and permissive.

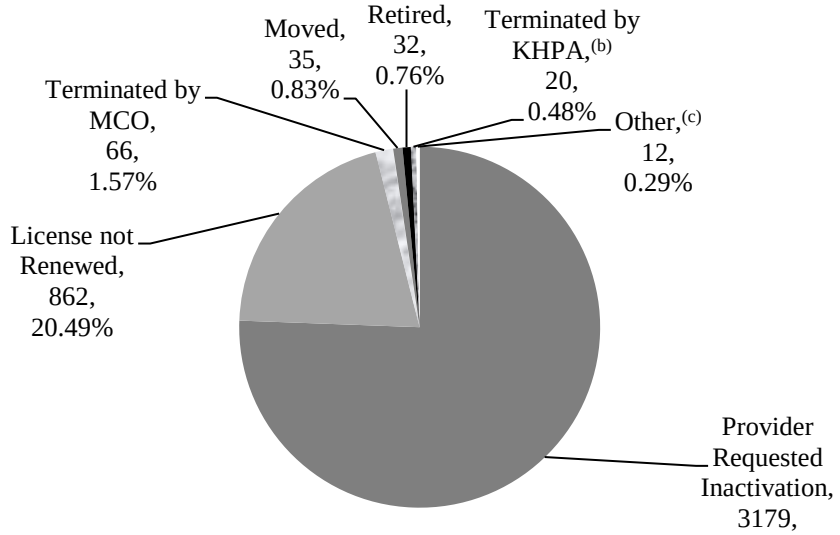
- Mandatory exclusions are: conviction of program-related crimes, conviction relating to patient abuse, felony conviction relating to health care fraud, and felony conviction relating to controlled substances.

- Permissive exclusions are imposed at the discretion of the HHS Office of Inspector General (OIG). They include among others: conviction relating to fraud; conviction relating to obstruction of an investigation or audit; license revocation or suspension; claims for excessive charges or unnecessary services; fraud, kickbacks, and other prohibited activities; and default on health education loan or scholarship obligations.[11]

An excluded provider cannot bill or cause bills to be submitted to any Federal health care program for direct or indirect services or for any administrative or management services.[12] However, an excluded provider may bill and receive payment for certain emergency services. Exclusion has national effect and applies even if the provider obtains another license or moves to another state. The HHS OIG maintains a list of excluded individuals or entities (LEIE) on its website.[13] OIG exclusions are also listed on the General Services Administration's publicly searchable website of all individuals and entities debarred by any Federal agency, known as the EPLS.[14] According to the KMAP Fraud and Abuse Business Practice Manual, fiscal agent staff queries the LEIE and EPLS lists monthly to check for excluded providers.

[9] https://www.kmap-state-ks.us/Documents/Content/Provider%20Manuals/Gen%20benefits_09222010_10113.pdf, page 2-24.
[10] Social Security Act, § 1128; 42 U.S.C. 1320a-7
[11] 42 USC 1320a-7
[12] OIG Special Advisory Bulletin: *The Effect of Exclusion from Participation in Federal Health Care Programs*. September 1999.
[13] The LEIE list may be found at: http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp
[14] The G.S.A.'s EPLS list is located at: https://www.epls.gov/

OV-3: FY 2010 Medicaid Provider Terminations or Inactivations by Reason [a]



[a] There were 4,206 providers terminated or inactivated in FY 2010.
[b] Includes providers terminated due to their inclusion on the LEIE and EPLS exclusion lists
[c] Other includes: Deceased, License Suspended/Revoked, No Claim Activity, No Agreement
Source: OIG analysis of KHPA documentation

The HHS OIG notifies KHPA of a provider's exclusion by a letter before the inclusion of the provider's name on the LEIE or EPLS list. This letter is sent to the Kansas Department of Social and Rehabilitation Services (SRS) and KHPA's provider and consumer relations manager and utilization review manager.

Upon receipt of the HHS OIG letter, KHPA notifies the provider in writing of the agency's intent to terminate participation and offers an administrative review at a time and date specified. The review must be more than five days but less than 10 days from the date of notification. If the provider does not complete the administrative review, the termination becomes effective 15 days after the date of the original notification letter.

Since the termination is due to Medicaid exclusion or loss of license, payments made to the provider for services rendered after the exclusion date or expiration date of the license are considered improper payments and must be recouped. The provider is notified of this potential overpayment in the original letter.[15]

[15] Termination of Provider from Title XIX Policy and Procedures, March 2, 1999

When the termination is effective, the fiscal agent provider enrollment staff is notified by memo or by copy of the decision letter. Staff inactivates the provider number and enters the effective date of termination in the MMIS.[16] System controls are designed to deny payment of services provided after the exclusion date for billing providers with inactivated numbers. In addition, there is a fraud-related edit in place, edit 1080, which can be set to deny any claim associated with an excluded provider.

[16] Termination of Provider from Title XIX Policy and Procedures, March 2, 1999

Does KHPA Prevent Excluded Providers from Enrolling in Kansas Medicaid?

Under the Congressional mandate contained in Sections 1128 and 1156 of the Social Security Act (SSA), the HHS OIG maintains the LEIE list which contains all currently excluded parties. The General Services Administration (GSA) maintains a similar list, the EPLS, under 31 U.S.C. 6101 and 48 CFR 9.404, et. al., of excluded entities not allowed to receive any compensation from federal health care programs, contracts, and certain federal financial and nonfinancial assistance and benefits. These databases are available online and come with updated monthly supplements and data dictionaries. Information provided includes individual or business name(s), exclusion date, addresses, and the reason for exclusion. These databases do not make SSN's available for viewing or download, but allow manual name and social security number verification on their websites.

OIG Testwork

We used computer-aided data matching to determine if there were any individuals or businesses on the LEIE and EPLS lists that were able to enroll as KMAP providers. We initially matched names and addresses, and conducted manual verifications with SSN's on the LEIE and EPLS websites. For a few providers, we reviewed enrollment documentation.

According to the provider and consumer relations manager, applicants are not required to provide their social security numbers. Although that information is requested on the provider enrollment form, it is KHPA's practice not to deny applicants on the basis of failure to provide an SSN. Without a unique identifier such as an SSN, excluded providers can escape detection if their names and addresses in the MMIS and the federal exclusion lists are not an exact match. KHPA's failure to collect SSNs could allow an excluded provider to enroll or continue to be enrolled in Kansas Medicaid.

Conclusion:
KHPA's provider enrollment process is effective in preventing excluded providers from enrolling in Kansas Medicaid. However, KHPA should collect more information through this process, deny incomplete applications, and use collected information to strengthen controls preventing payment of claims for services performed by excluded providers.

Recommendations:

1. KHPA program officials should ensure the KMAP enrollment applications include all federally-required information and should reject incomplete applications, such as those that do not provide the social security number of applicants, e.g. each individual in a group practice, and the taxpayer identification number of the provider organization.

Does KHPA Terminate Excluded Providers and Deny Payments for Services Rendered After the Exclusion Date?

K.A.R. 30-5-60 states that any provider participating in the Medicaid and Medikan programs may be terminated for various reasons, including civil or criminal fraud against Medicare, the Kansas Medicaid, Medikan or social service programs, and suspension or exclusion by the HHS Secretary from Title XVIII or Title XIX of the Social Security Act.

Based on 42 CFR 1001.1901, HHS states:

> *No program payment will be made for anything that an excluded person furnishes, orders or prescribes. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services, and anyone else. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.*[17]

Excluded Provider Terminations

We performed computer-assisted data matching to identify any individual or business providers excluded from participation in federally-funded healthcare programs after they had already enrolled as KMAP providers from fiscal year 2000 to 2010. We conducted additional analysis, including provider enrollment file reviews and social security number verifications, of our preliminary results.

We found all matched excluded providers were terminated from Kansas Medicaid. Details are as follows:

- Our LEIE data match identified 32 providers, comprised of one business and 31 individuals that were excluded after they had enrolled as KMAP providers. We did not assess the time lag between exclusion dates and KHPA termination dates for these providers. We did, however, review claims to determine if any were paid directly or indirectly for services rendered by these excluded providers after their effective exclusion dates.

- Our EPLS data match identified 33[18]providers, comprised of four businesses and 29

[17] http://oig.hhs.gov/fraud/exclusions/faq.asp#q3. Also see http://oig.hhs.gov/fraud/alerts/effect_of_exclusion.asp which states that, in many instances, the practical effect of an OIG exclusion is to preclude employment of an excluded individual in any capacity by a health care provider that receives reimbursement, indirectly or directly, from any Federal health care program.

[18] There is some duplication between the 32 LEIE matched providers and the 33 EPLS matched providers because an individual could be in both the LEIE and EPLS databases.

individuals that were excluded after they had already enrolled as KMAP providers. Three of the four businesses and 27 of the 29 individuals were terminated before their effective exclusion dates for various reasons, including no claim activity, voluntary inactivation, and the provider moving out of Kansas. One individual was terminated four days after being excluded in 2000, while the other individual was terminated almost three months after being excluded in 2001. We were not able to determine the MCO termination date of one excluded business provider enrolled in SCHIP.

According to the KHPA utilization review manager, in many instances providers are terminated by KHPA before their exclusion dates because KHPA may become aware of a conviction for Medicaid fraud or other cause warranting termination prior to the federal exclusion decision, which could take time. Providers may also voluntarily request inactivation before KHPA could take an adverse action.

Excluded Provider Payments

OIG auditors queried the MMIS for paid claims from FY 2000 to FY 2010 that were billed directly or indirectly by excluded providers. In this audit, we considered claims indirectly billed by excluded providers as those claims where the performing, attending, prescribing or surgical provider is an excluded individual.

Our analysis showed that KHPA did not pay any claims directly to any excluded provider. However, KHPA did pay claims that listed excluded individuals as performing, attending, prescribing or surgical providers, as shown in Table II-1 below. We provided these excluded providers' names and claim information to KHPA's provider enrollment and SURS staff.

II-1: Payments Associated with Excluded Providers FY 2000 - 2010

Excluded Provider	Provider Type Description	Number of Paid Claims	Amount Paid
Provider A[(a)]	Attending	6,365	$4,009,454
Provider B[(b)]	Attending	25	$49,978
	Prescribing	30	$1,977
	Total	6,420	$ 4,061,409

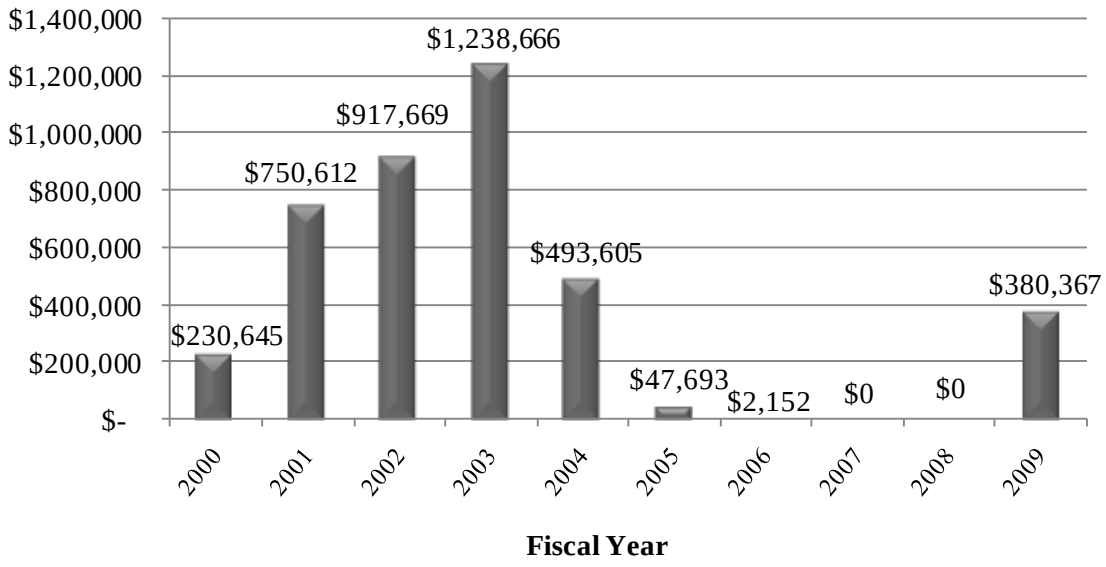
(a) Identified in long-term care claims, which may include room, board and attendant care services.
(b) Identified in long-term care and pharmacy claims.
Source: OIG analysis of LEIE and MMIS data

As shown in Chart II-2 on page 13, almost 90 percent of paid claims associated with excluded providers were paid prior to FY 2005. According to KHPA managers, the spike in 2003 resulted from claims adjudicated in the previous fiscal agent's system that were not paid until after transfer to the new MMIS in 2003. These claims were associated primarily with one individual

identified as an attending physician in four custodial care facilities (please refer to the profile box on page 14). These paid long-term care claims might include room, board, attendant care services and supplies.

The 2009 payments were attributable to the same attending physician identified prior to FY 2007. These payments were made for services rendered in FY 2003. According to KHPA managers, these long-term care claims were initially recouped after staff identified the provider as excluded in 2005 and found him to be the attending physician in these claims. However, the recoupment was done through a long-term care rate mass adjustment process rather than the correct recoupment process. The Kansas Department on Aging (KDOA) instructed KHPA and the fiscal agent to adjust the claims and repay the amount recouped from the provider. KHPA did not re-recoup that payment. We did not find any paid claims associated with excluded providers in FY 2010.

II-2: Payments Associated with Excluded Providers[(a)] by Fiscal Year[(b)]



[(a)] Providers include Attending, Performing, Prescribing and Surgical Providers
[(b)] Total amount paid to Excluded Entities = $4,061,409
Source: OIG analysis of LEIE & MMIS data

These claims may be improper because they appear to have been submitted for services performed by an excluded provider working in association with a billing provider who is legitimately enrolled. If an inactivated provider tried to bill KHPA directly, the MMIS edits would stop payment of the claim. Likewise, a fraud-related edit such as Edit 1080, if set up promptly for an excluded provider, would deny claims associated with non-billing performing, attending, surgical or prescribing providers.

Excluded Provider Profile

Physician A had a thriving practice before he was convicted of Medicare fraud, after a long running investigation by the federal government. The group practice he operated with his brother specialized in providing medical services to patients at numerous nursing homes. When the need arose, he referred those patients to specific hospitals for inpatient and outpatient services.

According to the federal government, Physician A and his brother had business arrangements with certain hospitals in Missouri and Kansas, whereby the hospitals would pay them ostensibly for "consulting" services. However, he and his brother provided no such services, and the payments were, in fact, kickbacks in return for their referral of patients to the hospitals. The indictment also included conspiring to file false Medicare and Medicaid claims, alleging that physician visits to nursing homes were actually provided by licensed physician assistants, and witness-tampering for allegedly threatening a physician assistant who objected to the use of unlicensed unsupervised personnel.

One hospital made not only sham consulting agreements over the years to pay the brothers for referrals, but also agreed to refer specimens for testing to a laboratory owned by the brothers, then split laboratory fees with them, among other things. Two of the hospitals named in the indictment reached a settlement with the federal government.

Physician A and his brother were excluded from participation in federal healthcare programs beginning in February 2000. By matching the MMIS provider database with the excluded provider databases, we found that Physician A was still listed as the attending physician in claims billed by six KMAP business providers for services rendered after Physician A's exclusion.

Four custodial care facilities, which provide room, board and assistance with daily living activities, billed most of the claims after Physician A's exclusion, about $4.0 million. While a large portion of these claims may have been valid and not used directly to pay for Physician A's salary as attending physician, the HHS OIG prohibition applies not just to the excluded person, but also to any hospital or other provider who employs or contracts with the excluded person, or where the excluded person provides services. The practical effect of OIG exclusion is to preclude employment of an excluded individual in any capacity by a healthcare provider that receives reimbursement, indirectly or directly, from any federal healthcare program.

Physician A died in a car accident in February 2002, two days before he was scheduled to report to prison to serve time for Medicare fraud. The four custodial care facilities continued to list him as the attending physician in claims for services that were allegedly provided after his death. About $2.3 million of the $4.0 million in claims listing him as the attending physician after his exclusion were for services rendered after his death. About $380,000 of this amount was paid in FY 2009, seven years after he died. KHPA initially recouped the $380,000 through a long-term care rate mass adjustment instead of the normal recoupment process. In 2009, based on a request from the Department on Aging, KHPA reprocessed and paid the claims. To date, KHPA has not re-recouped these payments.

Two of the custodial care facilities have not participated in Medicaid since 2005. One facility discontinued participation in Medicaid in 2006, but is currently a provider for one of KHPA's HealthWave managed care organizations beginning in January 2007. One facility is still actively participating in Medicaid.

Conclusion:
KHPA's procedural controls include having program personnel terminate all Medicaid enrolled excluded providers upon receiving notification from CMS, as required by law. However, existing system controls do not effectively identify and prevent payments associated with non-billing excluded providers such as those who carry out performing, attending, prescribing or surgical services.

Recommendations:

2. KHPA program officials should review, modify and apply edits and other program controls to deny or suspend claims for services provided by non-billing excluded providers.

3. KHPA management should review all payments to businesses that may have utilized the services of excluded individuals and should seek recoupment if warranted.

4. KHPA program officials should improve applicable provider manuals by including specific instructions to providers to check the exclusion lists before utilizing the services of any individual or entity, and by clearly stating that reimbursement cannot be claimed for services provided by excluded individuals.

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Appendix A: Agency Response

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KANSAS HEALTH POLICY AUTHORITY

February 15, 2011

Nick Kramer
Inspector General
Kansas Health Policy Authority
109 S.W. 9th Street, 7th Floor
Topeka, KS 66612-1280

Dear Mr. Kramer:

The Kansas Health Policy Authority (KHPA) has received the Office of the Inspector General's (OIG) report regarding its audit of KHPA's Medicaid provider enrollment and terminations and appreciates the opportunity to respond to the draft audit report. KHPA found the conclusions generated by the audit informative. We are pleased the audit findings revealed no systematic problems with the provider enrollment process that are not already being addressed because of the CMS Medicaid Integrity Group Program Integrity Review (MIG PI) and the Affordable Care Act (ACA).

KHPA Comments on OIG Conclusions and Recommendations

1. *Does KHPA prevent excluded providers from enrolling in Kansas Medicaid?*

***Conclusion**:*

KHPA's provider enrollment process is effective in preventing excluded providers from enrolling in Kansas Medicaid. However, KHPA should collect more information through this process, deny incomplete applications, and use collected information to strengthen controls preventing payment of claims for services performed by excluded providers.

Recommendation:

1. KHPA program officials should ensure the KMAP enrollment applications include all federally-required information and should reject incomplete applications, such as those that do not provide the social security number of applicants, e.g. each individual in a group practice, and the taxpayer identification number of the provider organization.

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www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

KHPA's response:

KHPA agrees with the recommendation and has begun the process of requiring this information. This was previously identified in the June, 2010, draft of the US Department of Health and Human Services Medicaid Integrity Group Program Integrity review (MIG PI). The MIG PI review recommended collection of the social security numbers and dates of birth for all persons with a controlling interest in the provider and for all managing employees. Additionally, the Affordable Care Act (ACA) requires collection of social security numbers and dates of birth. KHPA has updated the Disclosure of Ownership and Control Interest Statement and provider agreement to meet all the recommendations and requirements identified in the MIG PI review, items identified in a Best Practices In Provider Disclosures document released by CMS in August, 2010, as well as the new requirements established by the ACA. These will be implemented beginning in March, 2011.

Although this information was not a conditional requirement for enrollment for the time period of the review, the application asked for the information. Many applicants provided the information which was captured and stored with the provider's records.

> *2. Does KHPA terminate excluded providers and deny payments for services rendered after the exclusion date?*

***Conclusion**:*

KHPA's procedural controls include having program personnel terminate all Medicaid enrolled excluded providers upon receiving notification from CMS, as required by law. However, existing system controls do not effectively identify and prevent payments associated with non-billing excluded providers such as those who carry out performing, attending, prescribing or surgical services.

Recommendations:

2. KHPA program officials should review, modify and apply edits and other program controls to deny or suspend claims for services provided by non-billing excluded providers.

KHPA's response:

KHPA agrees with this recommendation. The system edit was not working as expected when the claims for provider "A" were submitted and claims were paid in error. The edit was corrected on 12/1/2005 and is posting as expected.

Provider "B" was inactivated due to no claim activity prior to being excluded; therefore, the editing for federal program exclusion would not have been applicable. At the time the claims were processed, prescribing providers were not required to be enrolled as Medicaid providers. While this will change with the implementation of the ACA, this requirement was not in place at the time the claims were processed.

The ACA requires "rendering, ordering and referring physicians and other professionals" to be enrolled with Medicaid. This recommendation will be resolved with the implementation of the ACA regulations.

3. KHPA management should review all payments to businesses that may have utilized the services of excluded individuals and should seek recoupment if warranted.

KHPA's response:

KHPA agrees with the recommendation. This activity will take place as part of the implementation on the Recovery Audit Contractor initiative.

4. KHPA program officials should improve applicable provider manuals by including specific instructions to providers to check the exclusion lists before utilizing the services of any individual or entity, and by clearly stating that reimbursement cannot be claimed for services provided by excluded individuals.

KHPA's response:

KHPA agrees with this recommendation and has begun taking steps to determine the most appropriate way to ensure providers are aware of their program integrity obligations and the potential consequences for being non-compliant with federal and state program integrity regulations.

We appreciate the efforts of the OIG's team in conducting the audit and being willing to discuss early drafts of the audit. We are grateful to your team's responsiveness to our comments. Thank you again for the opportunity.

Sincerely,

Andrew Allison, PhD
Executive Director

cc: Dr. Barbara Langner, Medicaid Director
Christiane Swartz, Medicaid Deputy Director and Director of Operations
Tamara Demmitt, Provider/Consumer Relations Manager

Appendix B: Acronyms

ARRA	American Recovery and Reinvestment Act of 2009
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
DME	Durable Medical Equipment
EPLS	Excluded Parties List System
FFP	Federal Financial Participation
FFS	Fee-for-Service
FY	State Fiscal Year
HCBS	Home and Community Based Services
HHS	Health and Human Services
K.A.R.	Kansas Administrative Regulation
KDOA	Kansas Department on Aging
KHPA	Kansas Health Policy Authority
KMAP	Kansas Medical Assistance Program
K.S.A.	Kansas Statute Annotated
LEIE	List of Excluded Individuals/Entities
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
NEMT	Non-Emergency Medical Transportation
OIG	Office of Inspector General
PAHP	Prepaid Ambulatory Health Plan
PIHP	Prepaid Inpatient Health Plan
SAS-70	Statement on Auditing Standards 70
SCHIP	State Children's Health Insurance Program
SRS	Social and Rehabilitation Services
SSN	Social Security Number
SURS	Surveillance and Utilization Review Subsystem